STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
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Mr. Chairman and Members of the Subcommittee:

On behalf of more than one million members of the Disabled American Veterans (DAV) and its Auxiliary, we are pleased to express our views on the four pieces of legislation before the Subcommittee.

Since its founding more than 80 years ago, the DAV has been dedicated to a single purpose: building better lives for America's disabled veterans and their families. Preservation of the integrity of the Department of Veterans Affairs (VA) health care system is of the utmost importance to the DAV and our members.

One of VA's primary missions is the provision of health care to our nation's sick and disabled veterans. The Veterans Health Administration (VHA) is the nation's largest direct provider of health care services with 4,800 significant buildings. This year, VHA projects it will provide health care services to over four million veterans. The quality of VA care is equivalent to, or better than, care in any private or public health care system. VA provides specialized health care services—blind rehabilitation, spinal cord injury care, Posttraumatic Stress Disorder treatment, and prosthetic services—that are unmatched. VHA has been cited as the nation's leader in tracking and minimizing medical errors.

The agenda for today's hearing includes H.R. 1720, the Veterans Health Care Facilities Capital Improvement Act; H.R. 116, the Veterans' New Fitzsimons Health Care Facilities Act of 2003; H.R. 2349, to authorize certain major medical facility projects for the VA; and H.R. 2307, to provide for the establishment of new VA medical facilities for veterans in the area of Columbus, Ohio, and in south Texas. DAV is especially concerned about maintaining a modern, effective, and safe system to meet the unique health care needs of our nation's veterans, which these bills address.

All four measures seek to improve VA's infrastructure when for more than a decade, VA has not been provided adequate appropriated funds for its major and minor construction projects. Equally important, these bills recognize the current state of VA's health care facilities nationwide, which have fallen into decay through the ravages of time and the obsolescence that comes so quickly when health care facilities are not regularly upgraded. The DAV has no resolution concerning these bills. However, because these issues have been addressed in *The Independent Budget*, we have no objection to them.

H.R. 1720

This measure authorizes the Secretary of Veterans Affairs to carry out construction projects costing not more than $100 million in FY 2004, $125 million in FY 2005, and $150 million in FY 2006 at locations of his choice. With authorization for $500 million in FY 2002, $600 million in FY 2003, and $700 million in FY 2006, the purpose of such projects are to improve seismic protection related to patient safety, fire safety, utility systems and ancillary patient care facilities, accommodation for persons with disabilities, and patient care facilities to specialized programs of the VA.

The approval of individual facility projects by the Secretary of Veterans Affairs will be based on recommendations of an independent capital investments board. In addition, the Secretary must report his actions to Congress. The bill would also mandate a review of this delegated-project approach by the General Accounting Office, to ensure this is an effective mechanism to advance some VA medical construction during and after the Capital Assets Realignment for Enhanced Services (CARES) process.

The problems addressed by H.R. 1720 are those we have specifically called attention to in the IB. Enactment of this bill would give the Secretary an opportunity to identify, consider, approve, and develop construction projects appropriately, with the authority and funds to do so. Many VA facilities need funds right now, on an emergency basis, for major construction and repair projects; other facilities have more chronic needs for restoration and capital improvements that have lingered unfunded for years.

In the June 1998 Price Waterhouse study, more than 42 percent of all VHA facilities were found to be at least 50 years old. Moreover, the report revealed VA invests less than 2 percent of the plant replacement value for its entire facility infrastructure when a minimum of 5 to 8 percent investment is necessary to maintain a healthy infrastructure. According to outside experts, such indicators paint a clear and disturbing picture. If construction funding continues to be inadequate, it will become increasingly difficult for VA to provide high quality services in old, inefficient, and unsafe patient care settings.

Notably, the CARES process is a major contributing factor to VA's diminutive annual budget for major medical construction projects. This nationwide initiative was implemented to realign and enhance VA health care infrastructure to effectively and efficiently meet the future needs of veterans. Deferrals of funds for needed construction projects were intended to permit CARES to proceed in an orderly way, avoiding unnecessary spending on health care facilities that might not be needed by veterans in the future.

Thus, while H.R. 1720 ensures an effective mechanism to advance some VA medical construction during and after the CARES process and its recommended $1.8 billion appropriation for three years, the IB recommends for FY 2003 alone that Congress appropriate $436 million for major construction, which includes $285 million to correct seismic deficiencies, and $490 million for minor construction. More must be done through the regular appropriations process in the annual budget for VA construction.

H.R. 116

Under this bill, the Secretary of Veterans Affairs is authorized to carry out major medical facility projects at the site of the former Fitzsimons Army Medical Center, Aurora, Colorado, and may include inpatient and outpatient facilities to provide acute, sub-acute, primary, and long-term care services. Using funds appropriated for FY 2004 through 2006 costing no more than $300 million for direct construction, capital leasing, or a combination of both, and $30 million for each fiscal year for capital leasing alone, the bill would also require the Secretary at the end of the process to report his actions to Congress.

Clearly there are many options to consider when implementing a major medical facility project as proposed in H.R. 116. In this instance and as with all VA medical affiliations, we believe VA should maintain a strong presence by keeping a separate identity with direct line authority in all areas involving care of veteran patients. This will allow VA to fulfill its primary health care mission to serve the needs of America's veterans by providing primary care, specialized care, and related medical and social support services.

DAV recognizes the importance of maintaining relationships with medical affiliates. Just as academic medical centers are under increasing financial pressures to reduce healthcare professional training, VA has mitigated this gap with training programs for VA and the nation. Last year, VHA's academic affiliates trained more then 85,000 clinicians. In addition to their value in developing the nation's health-care workforce, the affiliations bring first-rate health-care providers to the service of America's veterans.

The opportunity to teach attracts the best practitioners from academic medicine along with state-of-the-art medical science to VA. Veterans get excellent care, society gets doctors and nurses, and the taxpayer pays a fraction of the market value for the expertise the academic affiliates bring to VA. If enacted, H.R. 116 would allow construction of a freestanding self-contained medical facility, with sharing and coordination of certain support services. We would, however, have serious concerns with an integrated inpatient facility with joint governance and management.

H.R. 2349

This bill authorizes the Secretary of Veterans Affairs to carry out major medical facility projects and lease with specified amounts. Such projects include: new construction at the West Side VA Medical Center, Chicago, Illinois, not to exceed $98.5 million; new construction at Clark County, Nevada, not to exceed $97.3 million; seismic corrections to Medical Center Building 1, San Diego, California, not to exceed $48.6 million; renovation for all inpatient care wards and consolidation of medical research facility at West Haven, Connecticut, not to exceed $50 million; and lease for an outpatient clinic in Charlotte, North Carolina, not to exceed $3 million.

This bill would also restrict the use of any construction funds to dispose of Lake Side VA Medical Center, Chicago, Illinois, until such time as the Secretary of Veterans Affairs has entered into a construction contract at West Side VA Medical Center, Chicago, Illinois.

H.R. 2349 also provides for seismic corrections of Medical Center Building 1 of the San Diego VA Medical Center. This building is classified as "exceptionally high risk" (EHR) and such corrections would mitigate life safety hazards and allow for continued operation after a seismic event. In addition to patient and employee safety, seismic safety continues to be a major concern when 890 of VA's 5,300 buildings have been deemed at "significant" seismic risk and 73 VHA buildings are at EHR of catastrophic collapse or major damage. Indeed, these data leave no doubt that immediate remedial action is the only prudent course.

The bill would provide for new construction projects for a multi-specialty outpatient clinic Las Vegas, Nevada, and a bed tower to be consolidated with West Side VA Medical Center in Chicago, Illinois. Such projects would accommodate the loss of a VA medical facility in both areas and continue to provide a full continuum of high quality medical care.

H.R. 2307

Enactment of this measure would provide for major medical construction projects on available Federal land at the Defense Supply Center, Columbus, Ohio, with authorization of $90 million, and in South Texas with amounts appropriated for the construction of the medical facility not exceeding the amount equal to the product of the number of patient beds to be provided in the facility, and $290,000.

The DAV, along with the IB veterans service organizations, supports the CARES process; however, construction deferrals have resulted in adverse effects on health care quality and capacity, as well as the loss of capital asset value, and the overall inefficiency of delay. Such inaction does more than leave in place the unsatisfactory status quo; it is counterproductive inasmuch as it compounds existing problems and erodes the very foundation of the VA health care system. We look forward to working with the members of this Committee to obtain the funding necessary to restore and maintain a viable, modern, world-class health care system.

In closing, DAV sincerely appreciates the Subcommittee for holding this hearing and for its interest in improving benefits and services for our Nation's veterans. The DAV deeply values the advocacy this Subcommittee has always demonstrated on behalf of America's service-connected disabled veterans and their families. Thank you for the opportunity to present our views on these important measures.